State Tobacco Lobbyists and Organizations in the United States: Crossed Lines

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ABSTRACT

Objectives. This research took a quantitative look at state-level tobacco lobbying in the United States.

Methods. Publicly available lobbying data were collected from all states during 1994. Data were compiled on tobacco industry lobbyists, their tobacco employers, health lobbyists, and factors associated with such lobbying.

Results. In 1994, 450 tobacco industry lobbyists lobbied at a state level. Most lobbying was on behalf of four organizations: Philip Morris (34%), the Tobacco Institute (21%), RJ Reynolds (17%), and the Smokeless Tobacco Council (15%). Approximately one half of all tobacco lobbyists also lobbied for a health-related organization (e.g., state medical association, hospital, physician association).

Conclusions. All US states have tobacco lobbyists. Many health organizations knowingly or unknowingly employ lobbyists who also lobby for the tobacco industry. (*Am J Public Health.* 1996;86:1137–1142)

Introduction

Over the last 10 years, communities across the United States have passed tobacco control measures that regulate environmental tobacco smoke exposure.[1] However, broad public support for tobacco control initiatives has not translated into sustained increases in comprehensive state or federal tobacco control legislation.[2,3]

On the other hand, the tobacco industry remains exceptionally competent in defeating most state tobacco control legislation.[4] Legislators from tobacco-producing states block most federal tobacco legislation. Research has shown associations between federal and state legislators who accept campaign contributions from the tobacco industry and their votes on tobacco legislation.[5,6] While well-organized antismoking coalitions assist the passage of tobacco control legislation, no states have coalitions with the budget, experience, and resources to match the tobacco industry.[4,7]

Tobacco lobbyists are frequently mentioned as important agents influencing the outcome of tobacco-related legislation.[8–11] When tobacco measures are considered in state legislatures, tobacco control coalitions may have one part-time lobbyist, whereas tobacco organizations may have full-time lobbyists. There is little research, however, to document the extent of tobacco lobbying activity occurring at the state level.

The primary goal of this study was to determine the total number and characteristics of tobacco lobbyists employed nationally at the state level by tobacco organizations. We also determined the number of health lobbyists employed by health organizations, and, because most tobacco lobbyists represent more than one organization, we examined how many tobacco industry lobbyists lobby simultaneously for tobacco and health organizations.

Methods

In 1994, we obtained publicly available lobbyist data from all 50 US states. Lists were sent free of charge or were purchased from the appropriate agency (e.g., state ethics bureaus, election boards). Lists categorized lobbyists with their respective organizations and/or alphabetically by organization.

Two principal types of information were obtained from these lists: information on lobbyists (individuals who lobby on behalf of a private or public organization) and information on the private- or public-interest organizations represented by lobbyists (e.g., Philip Morris, state medical society).

From these lists, we created several variables. The first was total number of lobbyists in a state. If a lobbying firm was listed without specifying the individual lobbyist, the lobbying firm was counted as only one lobbyist, producing an underestimate of the total number of lobbyists. The second variable was total number of organizations (e.g., corporations, associations) that employed lobbyists. We were not able, through the sources used in this study, to distinguish whether lobbyists worked part or full time. The third

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Editor's Note. See related editorial by Fielding (p 1073) in this issue.

TABLE 1—Total Number of State Health and Tobacco Lobbyists in the United States, 1994

State	Population	Total No. Lobbyists	Total No. (%) Tobacco Lobbyists	Total No. (%) Health Lobbyists	Mean No. Organizations Employing Each Tobacco Lobbyist
Alabama	4 062 608	321	6 (2)	25 (8)	17
Alaska	551 947	255	3 (1)	11 (4)	4
Arizona	3 677 985	1 300	10 (1)	87 (7)	17
Arkansas	2 362 239	273	2 (1)	13 (5)	2
California	29 839 250	1 284	21 (2)	89 (7)	29
Colorado	3 307 912	369	13 (4)	41 (11)	26
Connecticut	3 295 669	632	11 (2)	106 (17)	19
Delaware	668 696	250	5 (2)	19 (8)	20
Florida	13 003 362	2 292	17 (1)	183 (8)	14
Georgia	6 508 419	916	6 (1)	45 (5)	7
Hawaii	1 115 274	255	7 (3)	11 (4)	5
Idaho	1 011 986	280	4 (1)	33 (12)	5
Illinois	11 455 682	4 222	10 (<1)	280 (7)	6
Indiana	5 564 228	500	10 (2)	26 (5)	12
Iowa	2 787 424	602	6 (1)	59 (10)	16
Kansas	2 485 600	616	7 (1)	42 (7)	8
Kentucky	3 698 969	641	7 (1)	35 (6)	5
Louisiana	4 238 216	565	7 (1)	16 (3)	13
Maine	1 233 223	250	9 (4)	14 (6)	16
Maryland	4 798 622	490	8 (2)	52 (11)	26
Massachusetts	6 029 051	557	7 (1)	56 (10)	6
Michigan	9 328 784	800	11 (1)	235 (29)	33
Minnesota	4 387 029	1 354	25 (2)	63 (5)	15
Mississippi	2 586 443	255	4 (2)	18 (7)	11
Missouri	5 137 804	2 024	13 (1)	201 (10)	28
Montana	803 655	824	10 (1)	44 (5)	4
Nebraska	1 584 617	376	6 (2)	39 (10)	13
Nevada	1 206 152	595	7 (1)	31 (5)	15
New Hampshire	1 113 915	190	4 (2)	19 (10)	6
New Jersey	7 748 634	270	6 (1)	66 (1)	42
New Mexico	1 521 779	1 097	3 (<1)	32 (3)	5
New York	18 044 505	1 854	9 (1)	75 (4)	8
North Carolina	6 657 630	512	13 (3)	46 (9)	8
North Dakota	641 364	451	11 (2)	27 (6)	8
Ohio	10 887 325	1 223	11 (1)	108 (9)	9
Oklahoma	3 157 604	489	5 (1)	36 (7)	13
Oregon	2 853 733	500	6 (1)	24 (5)	10
Pennsylvania	11 924 710	672	16 (2)	186 (28)	18
Rhode Island	1 005 984	328	8 (2)	13 (4)	7
South Carolina	3 505 707	331	9 (3)	32 (10)	10
South Dakota	699 999	339	4 (1)	23 (7)	7
Tennessee	4 896 641	465	11 (2)	69 (15)	16
Texas	17 059 805	1 937	7 (<1)	94 (5)	18
Utah	1 727 784	559	16 (3)	27 (5)	7
Vermont	564 964	317	14 (4)	32 (10)	10
Virginia	6 216 568	1 304	12 (1)	57 (4)	6
Washington	4 887 941	1 454	9 (1)	45 (3)	7
West Virginia	1 801 625	500	5 (1)	43 (9)	4
Wisconsin	4 906 745	614	12 (2)	62 (10)	8
Wyoming	455 975	664	7 (1)	9 (1)	5
Total	249 022 783	39 468	450 (1)	2 999 (8)	623
Mean/state	4 980 456	789	9 (1)	60 (8)	13
Range	...	190–4 222	2–25	9–280	2–42

Note. Population data were derived from the 1990 US Census.

variable, tobacco-related organizations, pertained to the name of an organization whose principal function was related to tobacco interests. Each tobacco organization in a state was counted once. When the same organization existed in two or more states, that organization was counted separately (e.g., Philip Morris has lobbyists in most states). The fourth variable was total number of tobacco lobbyists employed by the corresponding tobacco-related organizations. From this variable, we computed the total number of lobbyists in each state and the United States as a whole. The mean number of tobacco lobbyists per tobacco organization within and across all states was derived by dividing the total number of tobacco lobbyists by the total number of tobacco organizations. The fifth variable, number of lobbying organizations per lobbyist, represented the total number of organizations in a state represented by an individual tobacco lobbyist. From this variable, we computed the mean number of lobbying organizations that tobacco lobbyists worked for within a state.

We also examined the number of health lobbyists representing health-related organizations in states. We defined health lobbyists broadly to include organizations lobbying for physicians, dentists, nurses, hospitals and voluntary health associations, pharmaceutical companies, allied health organizations, and other health care corporations. Finally, we recorded the number of health organizations that employed a lobbyist who also lobbied for the tobacco industry.

Microsoft Excel (version 4.0) descriptive and comparison statistics were used in recording and analyzing data.

Results

Lobbying lists revealed that, in 1994, a total of 36 468 lobbyists were active at a state level for one or more organizations. Of these lobbyists, 450 (1%) represented tobacco-related organizations (Table 1). All states had tobacco lobbyists (mean per state = 9, range = 2 to 25). Each tobacco lobbyist worked, on average, for 13 lobbying organizations (range = 2 to 42). In comparison with the 450 lobbyists working for tobacco organizations, there were 2999 lobbyists (8%) working for health-related organizations. States had an average of 60 health lobbyists (range = 9 to 280).

The distribution of health lobbyists by their primary affiliated health organization showed that hospitals, hospital associations, and health care associations represented 52% of all health lobbying organizations, with 1546 employed lobbyists. Professional medical associations, academic medical centers, and medical associations employed 806 health lobby-

TABLE 2—Health Organizations That Employ Tobacco Industry Lobbyists, 1994, by State

State	Total No. Health Organizations Employing Tobacco Lobbyists	Heart, Lung, & Cancer Soc.; Public Health & Children's Assoc.; Health Depts.	State & County Med. Assoc.	Profess. Med. Assoc. & Soc.; Academic Med. Ctrs	Tobacco Control Groups	Hospitals & Hospital Assoc.; State Health Care Assoc.	Nurses' Assoc.	Dental Profess. & Hygienists	Pharma-ceutical	Psychiatry; Psychology	Optometry; Chiropractic	Ambulance Assoc.	Med./Health Care Corp.	Other[a]
Alabama	10			✓		✓			✓				✓	✓
Alaska	0													
Arizona	11					✓			✓		✓	✓	✓	✓
Arkansas	0													
California	7					✓	✓						✓	
Colorado	6			✓		✓	✓			✓				
Connecticut	9			✓		✓			✓			✓		✓
Delaware	6			✓		✓		✓	✓		✓		✓	
Florida	13			✓		✓			✓		✓		✓	✓
Georgia	3			✓					✓				✓	
Hawaii	1										✓			
Idaho	0													
Illinois	9			✓		✓			✓	✓		✓		✓
Indiana	6			✓			✓	✓					✓	✓
Iowa	3								✓	✓				
Kansas	1						✓							
Kentucky	3					✓	✓		✓					
Louisiana	13			✓		✓		✓	✓	✓		✓	✓	✓
Maine	4								✓		✓			✓
Maryland	10			✓		✓							✓	✓
Massachusetts	1													✓
Michigan	25			✓		✓			✓	✓	✓		✓	✓
Minnesota	7									✓	✓		✓	
Mississippi	9			✓		✓			✓	✓	✓			✓
Missouri	14			✓		✓		✓	✓	✓	✓			✓
Montana	2										✓			
Nebraska	3			✓		✓					✓			✓
Nevada	7						✓							✓
New Hampshire	2										✓			✓
New Jersey	19			✓		✓			✓				✓	✓
New Mexico	0													
New York	4					✓			✓		✓			✓
North Carolina	6			✓				✓					✓	✓
North Dakota	6													✓
Ohio	14	✓	✓	✓			✓	✓					✓	✓

(Continued)

TABLE 2—*Continued*

State	Total No. Health Organizations Employing Tobacco Lobbyists	Heart, Lung, & Cancer Soc.; Public Health & Children's Assoc.; Health Depts.	State & County Med. Assoc.	Profess. Med. Assoc. & Soc.; Academic Med. Ctrs	Tobacco Control Groups	Hospitals & Hospital Assoc.; State Health Care Assoc.	Nurses' Assoc.	Dental Profess. & Hygienists	Pharma-ceutical	Psychiatry; Psychology	Optometry; Chiropractic	Ambulance Assoc.	Med./Health Care Corp.	Other[a]
Oklahoma	4			✓		✓			✓					✓
Oregon	4					✓			✓				✓	✓
Pennsylvania	8					✓					✓		✓	✓
Rhode Island	2												✓	✓
South Carolina	7			✓		✓		✓		✓	✓		✓	
South Dakota	2			✓							✓			
Tennessee	15			✓		✓			✓	✓	✓		✓	✓
Texas	5			✓							✓		✓	✓
Utah	0													
Vermont	6			✓							✓	✓		✓
Virginia	5		✓					✓					✓	
Washington	1										✓			
West Virginia	1					✓								
Wisconsin	7					✓			✓		✓		✓	✓
Wyoming	2												✓	✓
Total	303	1	2	24	0	24	7	8	20	10	21	5	23	30

[a]Includes rehabilitation clinics, alternative health care organizations, allied health organizations, mental health associations, social work organizations, etc.

ists, or 27% of all such lobbyists. Public health societies, nursing associations, and other health groups employed 631 health lobbyists (21%). In only nine states, representing a total of 16 lobbyists, was there a health lobbyist who was lobbying for an organization whose primary mission was the reduction of tobacco consumption.

Three hundred three health organizations employed lobbyists who also represented tobacco organizations (Table 2). Five major categories of health organizations stand out as employing such lobbyists: physician professional associations and societies; hospitals, hospital associations, and health care associations; pharmaceutical organizations; optometry and chiropractic associations; and medical/health care corporations. States had, on average, 6 health-related organizations that employed tobacco lobbyists. Ten states (Michigan, New Jersey, Tennessee, Missouri, Ohio, Louisiana, Florida, Arizona, Alabama, and Maryland) had 10 or more health organizations that employed such lobbyists. Of all tobacco lobbyists, 220 (49%) also worked as a lobbyist for at least one health-related organization.

Figure 1 displays the total number of state tobacco lobbyists by tobacco organization. Four tobacco organizations—Philip Morris, the Tobacco Institute, RJ Reynolds, and the Smokeless Tobacco Council—employed 87% of the 450 tobacco lobbyists. Philip Morris and the Tobacco Institute had lobbyists in all but four states.

Discussion

Our research shows that the tobacco industry had at least 450 state-level lobbyists working on tobacco-related legislation in 1994. These lobbyists had a presence in all US states, and 20 states had 10 or more tobacco lobbyists. In and of itself, this number is perhaps not too surprising, particularly since tobacco companies have strong financial interests in tobacco legislation. For instance, Philip Morris and RJR Nabisco had combined profits in 1994 of more than $5 billion on revenues of more than $80 billion.[12,13]

Tobacco industry lobbyists also lobby for an average of 13 organizations, including tobacco, advertising, insurance, vending machine, alcohol beverage, restaurant, convenience store, bank, and other agencies. These alliances offer the industry a chance to attach its interests more

broadly to groups that otherwise may or may not have an interest in the outcomes of tobacco control legislation.

However, despite the seemingly large number of tobacco lobbyists at a state level in the United States, there are seven times as many health lobbyists as tobacco lobbyists. Some of these health organizations have taken active roles in lobbying for stronger tobacco control legislation, but most have many interests other than the prevention of tobacco-related diseases.[4,8] Since such organizations have an ability to join in lobbying efforts that will allow for more effective tobacco control coalitions, and since tobacco control coalitions that are well organized have greater potential to counter activities of tobacco industry lobbyists, public health advocates should encourage all health organizations to devote a portion of their lobbying efforts to supporting broad-based tobacco control efforts.[4,7]

Given that there are a very large number of health lobbyists and that tobacco lobbyists represent many different organizations, it is also perhaps not surprising that many tobacco lobbyists also represent health organizations. However, important ethical questions are raised by the fact that almost one of every two tobacco lobbyists also lobbies for a health organization, along with the fact that more than 300 health organizations in the United States employ on their behalf a lobbyist who also works for the tobacco industry. Moreover, our estimate of the number of health-related organizations with such a conflict is conservative because we excluded from consideration organizations such as insurance companies that have health-related and non-health-related missions.

Health organizations that employ tobacco industry lobbyists are faced with potential or real institutional conflicts of interest. Therefore, it is incumbent on health organizations and their constituents to know the details of all lobbying and financial arrangements. Other researchers have pointed out the ethical inconsistencies for health organizations that invest in tobacco industry stocks.[14] Our research shows that such inconsistencies extend across the United States and throughout many health care organizations.

Lobbyists who work for both health and tobacco organizations also have potential and real individual conflicts of interest. Such lobbyists are not likely to lobby on behalf of health organizations for any tobacco use reduction measure for fear of offending their tobacco employer. While officials of the American League of Lobbyists do not think that this represents a conflict of interest, they do think that it is inconsistent for a lobbyist to lobby for both tobacco and health organizations.[15] Lobbyists have a minimum duty to inform new and existing clients of potential conflicts to allow for more honest deliberations.

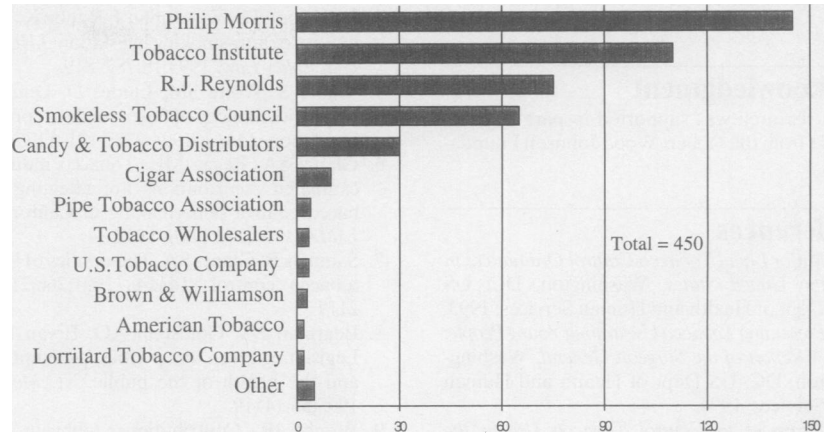

FIGURE 1—Total number of state tobacco lobbyists, by organization.

The potential adverse effects on public health of such conflicts of interest were demonstrated recently in Florida, where lawmakers had passed legislation in 1994 making it easier for the state to pursue its $1.4 billion lawsuit on recovering Medicaid expenses for smoking-related illnesses. A bill to repeal the legislation passed the Florida state senate in April of 1995, supported by a 53-member lobbying team assembled by the tobacco industry.[16] Two thirds of the tobacco industry lobbyists also represented hospitals and health insurance companies. The lead lobbyist for Philip Morris at the time reported that "we wanted to have the first team, the best people we could possibly find.... We didn't care about their other clients."[16] By hiring health lobbyists to work for the tobacco industry, the industry assured itself of detailed information about important health care bills, thus allowing it to "try to pass [bills] in every conceivable form at every conceivable opportunity."[16]

Limitations to our analysis primarily stem from the source of the data. Some states have different procedures and formats for recording lobbying information, thus making it less accurate to use lobbying lists for comparisons between different states. It is also impossible to determine from the lobbying lists whether or not lobbyists work part time or full time, how much they are paid for lobbying, or the extent or effectiveness of their lobbying activities. Such information, while very important to an understanding of the full extent of lobbying efforts, is not completely obtainable under most circumstances.

Our analysis showing 450 state tobacco lobbyists in the United States probably underestimates the extent of tobacco-related lobbying occurring at the state level for several reasons. As demonstrated with the earlier example in Florida, tobacco organizations frequently will hire more lobbyists to work on a campaign as an important bill advances in a state legislature. In addition, tobacco organizations may hire lobbying or public relations firms to lobby on their behalf without disclosing the source of the lobbying effort.

In conclusion, our analysis shows that the number of lobbyists working for the tobacco industry at the state level is not nebulous, but can be counted, tracked, and used by concerned participants. Public health leaders should understand the strategic importance that the tobacco industry places on state-level lobbying. Understanding the rationales, trends, and meanings behind these numbers will ultimately lead to an improved under-

standing of ways to affect legislative issues that decrease tobacco consumption. □

Acknowledgment

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A New Route of Transmission for *Escherichia coli:* Infection from Dry Fermented Salami

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ABSTRACT

Objectives. This study evaluated the production of dry fermented salami associated with an outbreak of *Escherichia coli* O157:H7 infection in Washington State and California.

Methods. Facility inspections, review of plant monitoring data, food handler interviews, and microbiological testing of salami products were conducted.

Results. Production methods complied with federal requirements and industry-developed good manufacturing practices. No evidence suggested that postprocessing contamination occurred. Calculations suggested that the infectious dose was smaller than 50 *E. coli* O157:H7 bacteria.

Conclusions. Dry fermented salami can serve as a vehicle of transmission for O157:H7 strains. Our investigation and prior laboratory studies suggest that *E. coli* O157:H7 can survive currently accepted processing methods. (*Am J Public Health.* 1996;86:1142–1145)

Introduction

Dry fermented salami is representative of a class of traditional products in which raw, ground meat is preserved by a process of fermentation and drying.[1] The lowered pH caused by fermentation and the decreased available moisture caused by drying, when combined with the inhibitory effects of salt, curing agents, and other spices, create a hostile environment for most pathogenic bacteria.[2,3] These products are considered ready to eat and are generally not cooked before consumption.

In November 1994, an outbreak of 17 cases of *Escherichia coli* O157:H7 infection in Washington State and California was linked epidemiologically to consumption of presliced dry fermented salami (brand A).[4] *E. coli* O157:H7 had been isolated from two intact packages of brand A salami collected at the retail level, with isolates from patients and the implicated salami having identical patterns by restriction fragment-length polymorphism analysis. Salami implicated in these outbreaks had been produced by a single facility (plant S) on August 25, 1994. Hypotheses for the presence of *E. coli* O157:H7 in this ready-to-eat product included the following: (1) Organisms present on raw meat ingredients survived a substandard fermentation and drying

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